

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4891 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 245

04880

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George's		MARYLAND		STATE Md		COUNTY Prince George's	
CITY (If outside corporate limits, write OR and give nearest town) 25 Riverdale		RURAL LENGTH OF STAY (in this place) 50 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5401 Riverdale Road				STREET ADDRESS (If rural, give location) 5401 - Riverdale Road			
3. NAME OF DECEASED: (First) Louise (Middle) (Last) Allen				4. DATE OF DEATH 5-7-1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED: Wid.		8. DATE OF BIRTH: Feb 21, 1970	
9. AGE last birthday: 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Christian Science Practitioner		11. BIRTHPLACE (State or foreign country): Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Jacob Eicholz				14. MOTHER'S M maiden NAME: Eleuthera Mehrling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: -		17. INFORMANT & ADDRESS: Miss Elizabeth Perkins Baltimore, Md.			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
442X Immediate cause		(a) Exhaustion			
Antecedent cause(s)		DUE TO			
Diseases or conditions, if any, giving rise to the above cause		(b) Myocarditis & nephritis			
stating underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE John W. Maloney (Hyaltonville, Md.) M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. 5-7-55					
23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION		DATE THEREOF 5/11/55		NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY SUTLAND MARYLAND	
DATE REC'D BY LOCAL REG May 7 1955		REGISTRAR'S SIGNATURE Jas. Deveser		24. FUNERAL DIRECTOR W. W. CHAMBERS ca-RIVERDALE Md.	

RECEIVED
MAY 12 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4892 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 231

04881
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE		COUNTY <u>47X.3</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Chesley</u>		<u>5 day</u>		TOWN <u>Washington D.C</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Sm. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>1809-Monroe St. N.P.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Thomas Patterson Allsworth</u>				(Month) (Day) (Year) <u>MAY 22nd 1955</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-10-1877</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Richard Hunter Bn. Printing & Engr.</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>John Allsworth</u>				14. MOTHER'S MAIDEN NAME: <u>Maud (Maudie name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Katherine Maloney - Same address</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
904.0 Immediate cause (a) <u>Cerebral compression</u>							
DUE TO <u>Subdural hemorrhage</u>							
Antecedent cause(s) (b) <u>Fall in home</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.,) OF INJURY <u>Home</u>		21c. (City or town) (County) <u>Washington, D.C.</u>		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-16-55 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall in home</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John D. Maloney (Hyattsville, Md.)</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-22-55</u>			
DEPUTY MEDICAL EXAMINER				ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>5/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		LOCATION (City, town, or county) (State) <u>College Park Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Monica Downey</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Riverdale Md</u>		ADDRESS	

This body is released to District of Columbia authorities
who will conduct their own investigation.
John D. Maloney, M.D.

5/22/55

Released to the State of
Maryland. R.M. Ruchergms
Acting Coroner

RECEIVED
MAY 26 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4893

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04882
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Md		COUNTY P. Geo	
CITY (If outside corporate limits, write OR and give nearest town) 38 TOWN Cheverly		LENGTH OF STAY (in this place) D.O.G.		CITY (If outside corporate limits, write OR and give nearest town) OR TOWN Seat Pleasant		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 99 Prince Georges Gen. Hosp.				STREET ADDRESS (If rural, give location) 6829 - Roosevelt Ave			
3. NAME OF DECEASED: (First) George (Middle) Andrew (Last) Augustine				4. DATE OF DEATH 5-23-55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 1-28-19	
9. AGE last birthday: 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Barber		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: John Augustine				14. MOTHER'S MAIDEN NAME: Julia Barkanda			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Father - Same address	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
330X Immediate cause		(a) Cerebral Compression			
Antecedent cause(s)		DUE TO Subarachnoid hemorrhage			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b) DUE TO			
(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: 2		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
SIGNATURE John J. Maloney (Hyattsville Md)		CHIEF MEDICAL EXAMINER		DATE SIGNED 5-23-55	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 5/25/55		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
LOCATION (City, town, or county) (State) Suitland, Maryland		24. FUNERAL DIRECTOR Francis Gasch's Sons - Hyattsville, Md.		ADDRESS	
DATE REC'D BY LOCAL REG. 5/24/55		REGISTRAR'S SIGNATURE Amanda L. Loney			

RECEIVED

MAY 26 1955

BUREAU V. S.

04883

MARYLAND

STATE DEPARTMENT OF HEALTH

4894

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. Geo.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
TOWN <u>Laurel</u>		TOWN <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 9th Street</u>		STREET ADDRESS (If rural, give location) <u>217 9th St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ira L.</u> (Middle) <u>BEALL</u> (Last) <u>BEALL</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>7</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 12, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip T. Beall</u>		14. MOTHER'S MAIDEN NAME <u>Ann A. Penn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Melvin Thacker Laurel, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a) <u>Bronchopneumonia</u>			<u>5 days</u>
Antecedent cause(s) (b) <u>Myocardial Failure</u>			<u>5 Wks.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u>			<u>5 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Bronchitis</u>			<u>10 yrs.</u>
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/5</u> , 19 <u>38</u> , to <u>5/7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>55</u> , and that death occurred at <u>5:57</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>J. M. Warren M.D.</u>		DATE SIGNED <u>5/7/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Fry Hill Cemetery Laurel, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>May 9-55</u>		24. FUNERAL DIRECTOR <u>De Witt Donaldson Laurel, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 11 1955

RECEIVED

04884

MARYLAND

STATE DEPARTMENT OF HEALTH

4929

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY Prince George MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Hill HOSPITAL OR INSTITUTION OR STREET ADDRESS 01		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Geo. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Hill STREET ADDRESS (If rural, give location) 3713 Andover Place	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) JESSE LOUISE BRIGHTMAN		4. DATE OF DEATH (Month) (Day) (Year) MAY 12 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED married	8. DATE OF BIRTH 11/27/74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 80 yrs.
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ervin M. Antosh		14. MOTHER'S MAIDEN NAME Mary Lavasca	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no none		16. SOCIAL SECURITY No. none	
17. INDEMNITY AND ADDRESS 3713 Andover P.D.E.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X Immediate cause (a) cerebral hemorrhage			2 days
Antecedent cause(s) (b) cardio-vascular-renal disease			6 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) No		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/7/36, 19 to 5/12/55, 19, that I last saw the deceased alive on 5/12, 1955, and that death occurred at 4 A.M., from the causes and on the date stated above.			
SIGNATURE Capt. J. Bosworth, M.D.		ADDRESS 811-8-N.E.	
DATE SIGNED 5/12/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE 5/14/55	
NAME OF CEMETERY OR CREMATORY Cedar Hill		LOCATION (City, town, or county) (State) Baltimore Md.	
DATE REC'D BY LOCAL REG. May 12, 55		REGISTRAR'S SIGNATURE Carrie Campbell	
24. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS 517 11th St. S.E. D.C.	

MARGIN RESERVED FOR BINDING

BUREAU V. 2

MAY 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04885

4895

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Prince Georges</i>		
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Carol Hills</i>				
38 TOWN <i>Cheverly</i>		22 hrs.		STREET ADDRESS (If rural give location) <i>1405 Boone Hill Rd.</i>				
17 HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Georges Gen. Hospital</i>								
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)				
<i>Rodney J Broadwater</i>				DEATH: <i>5 24 1955</i>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>Male</i>	<i>White</i>	<i>Single</i>	<i>4-8-41</i>	<i>14</i> yrs.	Months	Days	Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>minor</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>minor</i>		11. BIRTHPLACE (State or foreign country): <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Harry Broadwater</i>				14. MOTHER'S MAIDEN NAME: <i>Virginia Winters</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or upon) (If Yes, give war or dates of service) <i>4 no</i>				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT & ADDRESS: <i>Virginia Broadwater Carol Hills Md. 1405 Boone Hill Rd.</i>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
414X IMMEDIATE CAUSE								
ANTECEDENT CAUSE (S)								
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.								
(A) <i>Sub acute bacterial endocarditis</i>							<i>1 1/2 wks.</i>	
(B) <i>Rheumatic heart disease</i>							<i>?</i>	
(C)								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>none</i>								
19A. DATE OF OPERATION: <i>2</i>				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <i>1/23</i> , 1955 to <i>5/24</i> , 1955 that I last saw the deceased alive on <i>5/24</i> , 1955, and that death occurred at <i>12:50</i> P.M. from the causes and on the date stated above.								
SIGNATURE <i>Joseph C. Rawlings Jr.</i>		M. D.		ADDRESS <i>6124 Central Ave. Capt. Peto</i>		DATE SIGNED <i>5/24/55</i>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)		
<i>Burial</i>		<i>5/27/55</i>		<i>Washington Nat'l Cemetery</i>		<i>Md.</i>		
DATE REC'D BY LOCAL REGISTRAR <i>5/25/55</i>		REGISTRAR'S SIGNATURE <i>Annanda Downey</i>		24. FUNERAL DIRECTOR <i>W W Chambers Co</i>		ADDRESS <i>517-11 St SE</i>		

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED MAY 31 1955

BUREAU V. S.

MAY 31 1955

RECEIVED

4896

04886

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 231

I. PLACE OF DEATH:

COUNTY

Prince Georges

MARYLAND

CITY (If outside corporate limits, write name of nearest town)

Cheverly

LENGTH OF STAY (in this place)

1 day

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Prince Georges Gen. Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Prince Geo

CITY (If outside corporate limits write name of nearest town)

OR TOWN

Hyattsville

15

STREET ADDRESS

4625 - Baltimore Ave

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

William Earl Brotherton

4. DATE OF DEATH

(Month)

(Day)

(Year)

5-9-55

5. SEX:

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Single

8. DATE OF BIRTH:

Aug-29-1939

9. AGE last birthday:

15

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

School-boy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Jesse Brotherton

14. MOTHER'S MAIDEN NAME:

Hazel Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

9

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mother - Same address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

813X
Immediate cause

(a) DUE TO

Hemorrhagic shock

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Cerebral concussion & contusion

(c) DUE TO

Fractured skull

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

2

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE (Home, farm, factory, street, office, etc., of INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

5-8-55

M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Struck by auto while riding bicycle

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

SIGNATURE

John J. Maloney, Hyattsville, Md.

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

DATE SIGNED

5-11-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

5/12/55

NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

LOCATION (City, town, or county)

Colmar Manor Md.

(State)

DATE REC'D BY LOCAL REG

5/12/55

REGISTRAR'S SIGNATURE

Amanda Downey

24. FUNERAL DIRECTOR

F. Charles Jones Hyattsville Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1955
BUREAU V. S.

4897

CERTIFICATE OF DEATH

Reg. Dist. No. 239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>P. Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 5th St.</u>				STREET ADDRESS (If rural give location) <u>105 5th St. #3</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>William Maurice Branning Jr.</u>				<u>May 23 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married Aug 21, 1895</u>		8. DATE OF BIRTH: <u>59 yrs.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>signal maintainer B & O R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Laurel Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Harry Branning</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Garrison</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>If no</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>William M. Branning Jr. Laurel Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset and Death			
420.0 Immediate cause (a) <u>Myocardial Infarction, Ant. Acute</u>				3 days			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/21</u> 19 <u>55</u> , to <u>5/23</u> 19 <u>55</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>55</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Frank V. Weaver, Jr., M.D.</u>				ADDRESS <u>Laurel Md.</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 25, 1955</u>		<u>Long Hill Cemetery</u>		<u>Laurel Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 25 - 55</u>		<u>M. Braskie</u>		<u>Se with Donaldson</u>		<u>Laurel Md.</u>	

BUREAU V. S.

MAY 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04888

4930

CERTIFICATE OF DEATH

Reg. Dist. No. 242

Item 8, Film G182 6-14-55 et

1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/23, 1955, to 5/29, 1955, that I last saw the deceased

alive on 5/24, 1955, and that death occurred at 11:20 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

JUN 1 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

4886

04889

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Pr. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) 16 TOWN Mt Rainier		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Rainier 16	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 2901 Allison # 3 1	
3. NAME OF DECEASED (Type or Print)	(First) CLIFFORD	(Middle) ADELBERT	(Last) CHARLAND
5. SEX M	6. COLOR OR RACE W	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH JULY 8, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEC. CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	9. AGE last birthday 52 yrs.
13. FATHER'S NAME ALEXIS CHARLAND		14. MOTHER'S MAIDEN NAME JENNIE BAZETTE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No. 362-05-6451	
12. CITIZEN OF WHAT COUNTRY? USA		17. INFORMANT AND ADDRESS NEIL CHARLAND - MT RAINIER, MD - SON	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) CORONARY THROMBOSIS		1 HOUR
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CORONARY ARTERIOSCLEROTIC HEART Dis.		2 YRS.
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from MAY 1, 1953, to MAY 4, 1955, that I last saw the deceased alive on MAY 4, 1955, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

SIGNATURE Samuel M. Sugar MD		ADDRESS Mt. Rainier, Md		DATE SIGNED May 4, 1955	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5/6/55		NAME OF CEMETERY OR CREMATORY Mt. Rainier	
DATE REC'D BY LOCAL REG. May 4 1955		REGISTRAR'S SIGNATURE Mrs. Joe. Savere		24. FUNERAL DIRECTOR Gallagher's Funeral Home, Inc. 3200 R. S. Ave. Mt. Rainier, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 9 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04890

4898

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i> MARYLAND				STATE <i>Maryland</i> COUNTY <i>Prince Geo.</i>			
CITY (If outside corporate limits, write RURAL OR give nearest town) <i>38 Prince Georges, Maryland</i>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Landover, Maryland</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77 Prince Georges Dr. Hq.</i>				STREET ADDRESS (If rural give location) <i>E. Columbia Park</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Bill Compton</i>				DEATH: <i>May 16, 1955</i>			
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>n</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Jan. 8, 1918</i>	9. AGE last birthday <i>37</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Gen. Rep.</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Dr. Georges Self-Ent.</i>			
11. BIRTHPLACE (State or foreign country): <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME: <i>John Compton</i>				14. MOTHER'S MAIDEN NAME: <i>Lella Tolliver</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>war II</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <i>Hospital Records, Cherry Md</i>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>581.1</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>GASTRO INTESTINAL Hemorrhage</i>							<i>2 days</i>
(B) <i>Ruptured Esophageal Varices</i>							<i>3 mos.</i>
(C) <i>Cirrhosis of the Liver</i>							<i>6 mos.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>L'Aennec's</i>							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21F. HOW DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>5/15, 1955</i> to <i>5/16, 1955</i> that I last saw the deceased alive on <i>5/15, 1955</i> , and that death occurred at <i>10 A M</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm. D. D. Compton</i>				ADDRESS <i>M. D. 3503 62nd St. 2nd Prince Georges Md</i>			
DATE SIGNED <i>5/16/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>May 19, 1955</i>			
NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>				LOCATION (City, town, or county) (State) <i>Arlington Va</i>			
DATE REC'D BY LOCAL REGISTRAR <i>5/18/55</i>				REGISTRAR'S SIGNATURE <i>Amanda Souney</i>			
24. FUNERAL DIRECTOR <i>F. Gueha Sone</i>				ADDRESS <i>Hyattsville, Md</i>			

BUREAU V. S.

MAY 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4899

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04891

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>md</u> COUNTY <u>Pr. Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Dr. Hosp.</u>				STREET ADDRESS (If rural give location) <u>Box 178</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Baby Boy Crawford</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 15, 1955</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>5/14/55</u>	9. AGE last birthday: <u>—</u> yrs.	IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS.: Hours <u>20</u> Min. <u>25</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Charles Crawford.</u>				14. MOTHER'S MAIDEN NAME: <u>Hattie Chew</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>mother - as above</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>762.5</u> (A) <u>atelectasis</u>							
ANTECEDENT CAUSE (S) (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>5/14</u> , 19 <u>55</u> , to <u>5/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>55</u> and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE: <u>J. W. P. P. P.</u>				ADDRESS: <u>5301 Hamlet St, Hyattsville, Md</u>		DATE SIGNED: <u>5/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
<u>Shropshire</u>			<u>5/18/55</u>		<u>Prince Georges Dr. Hosp</u>		<u>Chesley Md</u>
DATE REC'D BY LOCAL REGISTRAR: <u>5/20/55</u>		REGISTRAR'S SIGNATURE: <u>Amanda Downey</u>			24. FUNERAL DIRECTOR: <u>Harry D. P. P. P.</u>		ADDRESS: <u>Cap</u>
<u>2055/7/26/</u>							

RECEIVED

MAY 23 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04892

4900

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince George</i> MARYLAND				STATE <i>Maryland</i> COUNTY <i>Prince Geo</i>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 <i>Cherely, Md</i>		2 <i>days</i>		6 <i>Brentwood, Md.</i> - X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <i>Prince George Pk. Hgts</i>				4401 - 40 th Street -			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>William FRANCIS Daly</i>				<i>May 20, 1955</i>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>	<i>Married</i>	<i>11-6-78</i>	<i>76</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>None</i>		<i>None</i>		<i>Ireland</i>		<i>U. S. A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>UNKNOWN</i>				<i>MARGARET HANLEY</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<i>NO</i>		<i>NONE</i>		<i>Statistic Card</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
181X IMMEDIATE CAUSE (A) <i>Melanoma Carcinoma</i>							
ANTECEDENT CAUSE (S): (B) <i>Carcinoma of the Breast</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Palmonary Tuberculosis</i>							
002X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8 May, 1955</i> , to <i>20 May, 1955</i> , that I last saw the deceased alive on <i>6 May</i> , 19 <i>55</i> , and that death occurred at <i>6:45 A.</i> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<i>Henry R. Wolfe</i>				<i>M. D. 5603 CHILCUM Hgts. Dr.</i>		<i>5/20/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>5/23/55</i>		<i>FORT LINCOLN</i>		<i>COLMER MANOR, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5/21/55</i>		<i>Armando Doney</i>		<i>W. W. CHAMBERS CO.</i>		<i>RIVERDALE, Md.</i>	

BUREAU V. S.

MAY 24 1955

RECEIVED

4901

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince George</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>162 Lafayette Ave.</u>		STREET ADDRESS (If rural give location) <u>162 Lafayette Ave.</u>	
3. NAME OF DECEASED: (First) <u>Charles</u> (Middle) <u>Spalding</u> (Last) <u>Davis</u>		4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married October 17, 1947</u>	9. AGE last birthday: <u>83</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>station agent B. & O. Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B. & O. Railroad</u>	
11. BIRTHPLACE (State or foreign country): <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Isaac Davis</u>		14. MOTHER'S MAIDEN NAME: <u>Frances Spalding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Thos. James Mealey, New Market, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
181X Immediate cause (a) <u>Hypertension Heart disease</u>		<u>2 yrs</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Carcinoma Bladder - Hypertension</u>		<u>from</u>	
(c) <u>—</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>			
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>—</u> SUICIDE <u>—</u> HOMICIDE <u>—</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u> (CITY OR TOWN) <u>—</u> (COUNTY) <u>—</u> (STATE) <u>—</u>	
TIME (Month) <u>—</u> (Day) <u>—</u> (Year) <u>—</u> (Hour) <u>—</u> (Minute) <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>4/26</u> , 19 <u>55</u> , to <u>5/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/4</u> , 19 <u>55</u> , and that death occurred at <u>4:30 pm</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. B. Leonard</u> (Degree or title)		ADDRESS <u>314 Compton Lane Laurel</u> DATE SIGNED <u>5/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 7, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) <u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 6 - 55</u>		REGISTRAR'S SIGNATURE <u>M. D. Shouse</u>	
24. FUNERAL DIRECTOR <u>Dr. W. L. Donaldson</u>		ADDRESS <u>Laurel Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1955

BUREAU V. S.

4887

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George		MARYLAND		STATE Maryland		COUNTY Prince George	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
16 TOWN Mt. Rainier		6 yrs		16 TOWN Mt. Rainier		16	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3006 - Arundel Road				STREET ADDRESS (If rural give location) 3006 - Arundel Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
John Francis Decker				OF DEATH: May 5 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 7/29/1891	
9. AGE last birthday: 63 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk				10B. KIND OF BUSINESS OR INDUSTRY: Ramsdell Co.			
13. FATHER'S NAME: William Decker				14. MOTHER'S MAIDEN NAME: Pierre			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): 9				16. SOCIAL SECURITY NO.: 577-05-7151		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 420.0						1 hr.	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						Arteriosclerotic Heart Disease 3 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: - 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug, 1954, to May, 1955, that I last saw the deceased alive on May 4, 1955, and that death occurred at 4 P. M. from the causes and on the date stated above.							
SIGNATURE Ralph R. Tuten M.D.				ADDRESS 8641 - Colmar Rd. Silver Spring, Md.		DATE SIGNED May 4, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
Burial		5/7/55		Fort Lincoln		Colmar Manor, Md.	
DATE REC'D BY LOCAL REGISTRAR 7/19/55				REGISTRAR'S SIGNATURE James Percy			
24. FUNERAL DIRECTOR				ADDRESS			
Halleys Funeral Home, Inc.				3200 - R.D. Ave. Mt. Rainier, Md.			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1955

BUREAU V. S.

4992

04895

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>P. D.</u>	MARYLAND	STATE <u>Ind.</u>	COUNTY <u>Pn.</u>
CITY (If outside corporate limits, write RURAL or give nearest town) <u>Chesapeake</u>	LENGTH OF STAY (in this place) <u>D.O.A.</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Fairmont Heights</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pn. D. Soc. Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>5900 S. St.</u>	1
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Daniel</u>	(Middle) <u>Dunlap</u>	(Last) <u>Dunlap</u>	(Month) <u>5</u> (Day) <u>22</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>17 April</u>
9. AGE last birthday: <u>47</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired): <u>Labr.</u>	11. BIRTHPLACE (State or foreign country): <u>S. C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>William Dunlap</u>		14. MOTHER'S MAIDEN NAME: <u>Janie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>unk.</u>	
17. INFORMANT & ADDRESS: <u>6411 Sheriff Rd. Rosetta Moore Cedar Heights, Ind.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
812 X Immediate cause	(a) <u>Hemorrhage & shock -</u>	
Antecedent cause(s)	DUE TO <u>Laceration of abdominal aorta</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) <u></u>	
	(c) <u></u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>5-22-55</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Street</u>	21c. (City or town) (County) (State) <u>Fairmont Hts - Pn. Soc - 16 Ind.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-22-55</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Pushed in - struck by automobile</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>John J. Maloney (Hyaltonville, Md.)</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-23-55</u>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>5/23/55</u>	NAME OF CEMETERY OR CREMATORY <u>467-N.H.</u>
LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	24. FUNERAL DIRECTOR <u>H. J. Washington & Son</u>	ADDRESS <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG <u>5/23/55</u>	REGISTRAR'S SIGNATURE <u>Amanda Doney</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 26 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4931

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04896

CERTIFICATE OF DEATH

Reg. Dist. No. 143

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE D. C. COUNTY -			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Glenn Dale (rural)		11 mos., & 11 days.		TOWN Washington		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Glenn Dale Hospital		STREET ADDRESS		1216 E. Cap. St.	
3. NAME OF DECEASED: (First) (Middle) (Last)		John W. Ellis		4. DATE OF DEATH: (Month) (Day) (Year)		5 22 1955	
5. SEX: Male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: 6-4-1892	
9. AGE last birthday: 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver		10b. KIND OF BUSINESS OR INDUSTRY: Self-employed		11. BIRTHPLACE (State or foreign country): Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: John Ellis		14. MOTHER'S MAIDEN NAME: Ella Holtzman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Decedent			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) DUE TO 162X Monogenic Carcinoma left lung						7 mo	
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. 1002X Pulmonary Tuberculosis						1 year	
19a. DATE OF OPERATION: 2						20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M.		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6:11:54 to 5:22, 1955, that I last saw the deceased alive on 5:22, 1955, and that death occurred at 12:30 a.m., from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
Daniel Leo Finucane		M.D.		Glenn Dale Hospital Glenn Dale, Md.		5/22/55	
23. BURIAL, CREMATION REMOVAL (Specify): Removal		DATE THEREOF: 5/23/55		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE RECD BY LOCAL REG. 5/22/55		REGISTRAR'S SIGNATURE: [Signature]		24. FUNERAL DIRECTOR: Walker Bradley 816 H. ST. N.E. D.C.		ADDRESS: No 37 Rinaldi Funeral Home	

RECEIVED
JUN 6 1955
BUREAU V. S.

4932

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 04897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Suitland</u>				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Silver Hill</u> 56			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4798 Silver Hill Rd</u>				STREET ADDRESS (If rural give location) <u>4798 Silver Hill Rd</u>			
3. NAME OF DECEASED: (First) <u>Thomas</u> (Middle) <u>Florio</u> (Last) <u>Florio</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>July 8, 1886</u>	
9. AGE last birthday: <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>factory</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME: <u>Paul Frank Florio</u>			
14. MOTHER'S MAIDEN NAME: <u>Francess Raimondo</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No.: <u>none</u>				17. INFORMANT & ADDRESS: <u>Mrs. Mary Florio, same address</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
442X Immediate cause (a) <u>acute congestive heart failure</u>							
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>4-2-1955</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. J. Bond</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-29-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>6-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>May 31-55</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 2 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4933 04898
CERTIFICATE OF DEATH Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>D.C.</u> <u>PG</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>25</u> <u>Riverdale</u>		LENGTH OF STAY (in this place) <u>24</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>76</u> <u>Eugene Leland Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>7300 Gateway Blvd., District Hqts.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Anna Menno Elsie Fuchs</u>				<u>May 9, 1955</u>			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 28, 1873</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Germany</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Charles E. Fuchs</u> <u>7300 Gateway Blvd.</u> <u>District Hqts. Washington 28, D.C.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>332X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <u>Cerebral Thrombosis</u>						<u>2 Mo.</u>	
(B) <u>General arteriosclerosis</u>						<u>5 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 15, 1955</u> to <u>May 9, 1955</u> , that I last saw the deceased alive on <u>May 9, 1955</u> , and that death occurred at <u>M., from the causes and on the date stated above.</u>							
SIGNATURE <u>L W Malin</u> M.D.				DATE SIGNED <u>Riverdale Mar 5-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-12-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Natl</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severance</u>		24. FUNERAL DIRECTOR ADDRESS <u>W.W. Chambers Co., Washington, D.C.</u>			

BUREAU V. S.

MAY 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04899

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Prince Georges.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 TOWN <u>Cheverly</u>		18 days		38 TOWN <u>Cheverly</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <u>Prince Georges General Hospital</u>				1 <u>6217 Forest Road.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Francis ALBERT Gessner</u>				OF DEATH: <u>5</u> <u>18</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>7/13/1908</u>	<u>46</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Milkman</u>		<u>Dairy</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Francis F. Gessner</u>				<u>Minnie Senka</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u>				<u>20</u>		<u>Statistic Card</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
156.1 IMMEDIATE CAUSE (A) <u>Ordnance carcinoma of lung</u>						<u>1 mo.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>55</u> , to <u>5-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>55</u> , and that death occurred at <u>11:25</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Francis F. Gessner</u>		M. D. <u>Hyatt Hark</u>		DATE SIGNED <u>5-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/21/55</u>		<u>Fort Lincoln</u>		<u>Colman Manor Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>5/20/55</u>		<u>Amanda Denny</u>		<u>F. Gessner Sons & Daughters Inc.</u>			

BUREAU V. S.

MAY 24 1955

RECEIVED

4883

CERTIFICATE OF DEATH

Reg. Dist. No. 100

245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George</u> MARYLAND		STATE <u>md</u> COUNTY <u>Prince George</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Sunset Heart Rest Home</u>		STREET ADDRESS (If rural give location) <u>5805 Queens Chapel Rd</u>		4. DATE OF DEATH: <u>May 10, 1955</u>		5. AGE last birthday: <u>83</u> yrs. Months <u>10</u> Days <u>19</u> Hours <u>55</u> Min.	
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Roberta</u> (Last) <u>Green</u>				6. DATE OF BIRTH: <u>1871</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>1871</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Francis B. Green</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia L. Wood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9 -</u>		16. SOCIAL SECURITY NO.: <u>-</u>		17. INFORMANT & ADDRESS: <u>Mrs. Stephen Latchford working for DC</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
252.0 Immediate cause (a) Congestive heart failure DUE TO						10 days	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hyperthyroid heart disease DUE TO						7 years	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7, 1943</u> , to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 9, 1955</u> , and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Thomas Kelch</u>				ADDRESS <u>322 H Street, N. E.</u> DATE SIGNED <u>5/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>5/12/55</u>		<u>St. Josephs</u>		<u>Pamphlet md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>5/12/55</u>		REGISTRAR'S SIGNATURE <u>Julia [Signature]</u>		24. FUNERAL DIRECTOR <u>Smith & Ryan</u> ADDRESS <u>md</u>			
Mr. Jas. [Signature]							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4882 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 04903

Reg. Dist. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges.	MARYLAND	STATE Md	COUNTY Prince Geo
CITY (If outside corporate limits, write OR and give nearest town) 15 TOWN Hyattsville	LENGTH OF STAY (in this place) 3 yrs	CITY (If outside corporate limits write OR TOWN Hyattsville	15
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1510 Madison St.		STREET ADDRESS (If rural, give location) 1510 Madison St	
3. NAME OF DECEASED: (First) Robert (Middle) Lee (Last) Harlow		4. DATE OF DEATH 5-6-1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Wid.	8. DATE OF BIRTH: Sept. 14, 1899
9. AGE last birthday: 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life): 10a. Retired U.S. Govt.	
11. BIRTHPLACE (State or foreign country): Georgia		12. CITIZEN OF WHAT COUNTRY: U.S.	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 220-34-4155	
17. INFORMANT & ADDRESS: Mrs. Georgia Throckmorton			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
163X Immediate cause (a) Exhaustion DUE TO			
Antecedent cause(s) (b) Pulmonary hemorrhage & toxemia DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Carcinoma of lung.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE John J. Maloney (Hyattsville, Md.)		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> 5-6-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 5-9-55	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) (State) Hyattsville, Maryland
DATE READ BY LOCAL REG. May 6 1955	REGISTRAR'S SIGNATURE James Devey	24. FUNERAL DIRECTOR W. W. Charles	ADDRESS 517 11th St SE

100

George

Washington

230 21-4123 Mr. George Washington

Mr. George

10

BUREAU V. S.

MAY 10 1955

RECEIVED

George Washington

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4933

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

049043

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9. Film G182, 6/9/55 fcy

1. PLACE OF DEATH:

COUNTY Prince Georges

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Glenn Dale (rural)

LENGTH OF STAY (in this place)

8 mos., & 1 day

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Glenn Dale, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D. C. COUNTY —

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Washington

STREET ADDRESS (If rural, give location)

1817 5th St., N. W.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

ROMEOD.HARRIS

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

(Month)

(Day)

(Year)

Male

Negro

Widowed

1/7/1900

55 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Painter

10b. KIND OF BUSINESS OR INDUSTRY:

Federal Government

11. BIRTHPLACE (State or foreign country):

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John T. Harris

14. MOTHER'S MAIDEN NAME:

Mildred ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Decedent

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

002x

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c).....

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

9 mos. & 10 days

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/29, 1955, to 5/30, 1955, that I last saw the deceased alive on 5/30, 1955, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

Glenn Dale Hospital

DATE SIGNED

Daniel Leo Pinescane M.D.Glenn Dale, Maryland5/30/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/30/55Wm. W. W.Henry J. Washington Sons 467-N St. N.W.

RECEIVED

JUN 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4934

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04995

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u>		MARYLAND		STATE <u>D. C.</u>		COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Glenn Dale (rural)</u>		<u>3 months and 3 days</u>		TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Glenn Dale Hospital</u>		STREET ADDRESS (If rural, give location)			
				<u>1419 Morris Road, S. E.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Lucille</u>		(Middle)		(Last) <u>Hawkins</u>		(Month) (Day) (Year)	
(Type or Print)						<u>May 1st 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>4/10/1914</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>-</u>		<u>Madison, Ga.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Amos Collins</u>				<u>Lutishia Foster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>579-32-9591</u>		<u>Decedent</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bronchogenic Carcinoma Rt. Lung</u>						<u>11 mos.</u>	
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
<u>2</u>							
20. AUTOPSY?							
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>January 28, 1955</u> , to <u>May 1st, 1955</u> , that I last saw the deceased alive on <u>May 1st, 1955</u> , and that death occurred at <u>8 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
<u>Daniel Leo Pinckney</u>		<u>M.D.</u>		<u>Glenn Dale Hospital</u>		<u>5/1/55</u>	
23. BURIAL CREMATION REGIONAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Funeral</u>		<u>5/5/55</u>		<u>Arlington Mt. Cemetery</u>		<u>Arlington, Va</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/2/55</u>		<u>Walter Wren</u>		<u>Malvan and Schey Inc. New Gray Rd.</u>			

RECEIVED
MAY 13 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04906

4905

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i> MARYLAND				STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>38</i> <i>Chesley, Maryland</i> LENGTH OF STAY (in this place) <i>12 hrs.</i>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>7704 Frederick Road X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77</i> <i>Prince Georges Gov. Hosp.</i>				STREET ADDRESS (If rural give location) <i>West Lantana, Ind!</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <i>Baby Boy Himelright</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>May 11, 19 55</i>			
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>n</i>	7. (SINGLE) MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>May 11, 1955</i>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Hemelright, Curtis</i>				14. MOTHER'S MAIDEN NAME: <i>Ruf. 2 Lane</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>mother, as above</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>762.5</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>Bilateral pneumonia atelectasis</i>						6 h.	
(B) <i>Prematurity</i>						12 h.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5-11</i> , 19 <i>55</i> , to <i>5-11</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5-11</i> , 19 <i>55</i> , and that death occurred at <i>5:30</i> M, from the causes and on the date stated above.							
SIGNATURE <i>R. B. Sauer MD.</i>				ADDRESS <i>Hyattsville, Md.</i>		DATE SIGNED <i>5-11-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Cremation</i>		<i>5/18/55</i>		<i>Prince Georges Gov. Hosp. Chesley Md</i>			
DATE REC'D BY LOCAL REGISTRAR <i>5/20/55</i>		REGISTRAR'S SIGNATURE <i>Amanda Sauer</i>		24. FUNERAL DIRECTOR <i>Harry W. Penn Jr.</i>		ADDRESS <i>capt</i>	

2055253291

RECEIVED

MAY 24 1955

BUREAU V. 2

04907

MARYLAND

STATE DEPARTMENT OF HEALTH

4889

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 3rd Avenue</u>		STREET ADDRESS (If rural, give location) <u>113-3rd AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u>	(Middle) <u>WILLIAM</u>	(Last) <u>HOLLOWELL</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>16</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 6, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Kinstonville, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. W. Hollowell</u>		14. MOTHER'S MAIDEN NAME <u>Betty Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>579-18-7823</u>	
17. INFORMANT AND ADDRESS <u>Edith L. A. Hollowell, 113 3rd Ave. T.P. Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1

Immediate cause

(a) Carcinoma of Liver, with metastasis to Lung.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

INTERVAL BETWEEN ONSET AND DEATH

8-12 Months

22. I hereby certify that I attended the deceased from May 1, 1955, to 16 May, 1955, that I last saw the deceasedalive on 16 May, 1955, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>May 19, 1955</u>	<u>St. Lenox Cemetery</u>	<u>Prince Geo. Co.</u>	<u>MD</u>

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 17, 1955 James PercyJ. Arthur Walters, 254 Carroll St. N.W. Tak Park D.C.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 10 1955
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i>	MARYLAND	STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>38 Cheverly</i>	LENGTH OF STAY (in this place) <i>2 hours</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Wheaton</i>	<i>15X-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77 Prince Georges Gen. Hosp.</i>		STREET ADDRESS (If rural give location) <i>11810 Valleywood Drive</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <i>5 31 1955</i>	
<i>Male</i>		<i>Jones</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>5/31/55</i>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>unemployed</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
13. FATHER'S NAME: <i>Richard Jones</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14. MOTHER'S MAIDEN NAME: <i>Margaret Engel</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <i>Statistic Card</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>762.5 Atelectasis</i>		
ANTECEDENT CAUSE (B) <i>Immaturity - 24 weeks gestation</i>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <i>2</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5/31*, 19*55*, to *5/31*, 19*55*, that I last saw the deceased alive on *5/31*, 19*55*, and that death occurred at *1:35* P.M., from the causes and on the date stated above.

SIGNATURE *Louis H. Moody, Jr.* M.D. *918 Ellsworth Drive S.E.* DATE SIGNED *6-1-55*

23. BURIAL, CREMATION, REMOVAL (SPECIFY) *Cremation* DATE THEREOF *6/15/55* NAME OF CEMETERY OR CREMATORY *Prince Georges Gen Hosp Cheverly Md* LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR *6/15/55* REGISTRAR'S SIGNATURE *Amanda Downey* 24. FUNERAL DIRECTOR *Harry W. Penn* ADDRESS *dup*

2055222230

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. 2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04909
4888 CERTIFICATE OF DEATH Reg. Dist. No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George's</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>P. G.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>16 Mt. Rainier</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>16 Mt. Rainier</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>08 3202-Bunker Hill Road</i>		STREET ADDRESS (If rural give location) <i>3202-Bunker Hill Road.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<i>TIMOTHY KANE</i>		<i>May 12th 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Aug 27th 1870</i>
		9. AGE last birthday: <i>84</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Plumber.</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>U.S. Government.</i>	11. BIRTHPLACE (State or foreign country): <i>Ireland.</i>
13. FATHER'S NAME: <i>John Kane.</i>		14. MOTHER'S MAIDEN NAME: <i>Bridget Ready.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS: <i>Mrs Mary Kane. 3202-Bunker Hill Road</i>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>25 months</i>	
IMMEDIATE CAUSE: <i>442X</i>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) DUE TO <i>Chronic Cardio-Vascular-Renal disease</i>			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3 April, 1955</i> to <i>12 May 55</i> , that I last saw the deceased alive on <i>6 May 55</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Robert E. Harbo</i>		DATE SIGNED <i>12 May 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <i>Burial</i>		DATE THEREOF: <i>May 16th 1955</i>	
NAME OF CEMETERY OR CREMATORY: <i>Mt. Olivet Cemetery</i>		LOCATION (City, town, or county) (State): <i>Ward D.C. -</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>May 12 1955</i>		REGISTRAR'S SIGNATURE: <i>Mrs. Jas. Sever</i>	
24. FUNERAL DIRECTOR: <i>T. F. Costello</i>		ADDRESS: <i>1722 North Cap St.</i>	

Mr. E. H. Harte

RECEIVED

MAY 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4906

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04910

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>38 TOWN Charles, Md.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brentwood, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>77 Prince Georges Ave., Hgt.</u>				STREET ADDRESS (If rural give location) <u>3600 Tilden Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Amey</u>				<u>May 7th 1955</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>11/10/1884</u>	9. AGE last birthday <u>70</u> yrs.	10. UNDER 1 YEAR Months <u>5</u> Days <u>27</u>	11. UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Captain with U.S. Navy Dept.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>New York City, N.Y.</u>			
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>John Galbraith</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-05-1033</u>			
17. INFORMANT & ADDRESS: <u>Marion Gerhardt</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>491X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>General Debility</u>						<u>2 wks</u>	
(B) <u>Senility</u>						<u>1 yr</u>	
(C) <u>Bronchial Pneumonia</u>						<u>4 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>5-2, 1955</u> , to <u>5-7, 1955</u> , that I last saw the deceased alive on <u>5-6, 1955</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. B. ...</u>				M. D. <u>W. B. ...</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>5/10/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>				LOCATION (City, town, or county) (State) <u>Columbia Manor Md. Prince Georges Co.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>May 9, 1955</u>				REGISTRAR'S SIGNATURE <u>Amanda Sweeney</u>			
24. FUNERAL DIRECTOR <u>Walter ...</u>				ADDRESS <u>3206 - ...</u>			

BUREAU V. S.

MAY 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04911

4907

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
38 TOWN <u>Cheverly</u>		3 days		OR TOWN <u>Laobam Hills</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <u>Prince Georges General Hosp.</u>				4921-78 th Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH: 5 - 10 1955			
(Type or Print) <u>Lillian L. LeCompte</u>							
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-26-1886</u>	9. AGE last birthday: <u>68</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>(Unknown) Spicer</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-20-8053</u>		17. INFORMANT & ADDRESS: <u>Statistic Card</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE							
(A) <u>Pulmonary edema</u>						2 hrs.	
ANTECEDENT CAUSE (S):							
(B) <u>Carcinoma of cervix</u>						4 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/2</u> , 1955, to <u>5/1</u> , 1955, that I last saw the deceased alive on <u>5/9</u> , 1955, and that death occurred at <u>8:40</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>B. Brummer</u>		M. D. <u>2409 V Avenue</u>		DATE SIGNED <u>5/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/13/1955</u>		NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>		LOCATION (City, town, or county) (State) <u>COLMAR Manor, Prince Georges Co.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/11/55</u>		REGISTRAR'S SIGNATURE <u>Theresa Downey</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co-Riverdale, Md</u>		ADDRESS	

STATE OF MARYLAND
DEPARTMENT OF HEALTH

BUREAU V. S.

MAY 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04912
4978 CERTIFICATE OF DEATH Reg. Dist. No. 231...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>38 TOWN Chevy Chase</i>	STATE <i>md.</i> COUNTY <i>Prince Georges</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>16 Mt. Rainier</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77 P. G. General Hospital</i>	LENGTH OF STAY (in this place) <i>1 month</i>	STREET ADDRESS (If rural give location) <i>3406 Newton St.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>James Donald Leighton</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>May 2 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>May 5, 1901</i>
9. AGE last birthday: <i>53</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Mass. —</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Salesman Rug Shampoo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John Edward Connelly</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah Leyden</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>3406 Newton St. Mt. Rainier, Md.</i>	
17. INFORMANT & ADDRESS: <i>Donald Lee Leighton Son</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
581.0 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>Pulmonary edema, Heart Failure</i>			
DUE TO			
(B) <i>Cirrhosis of liver</i>			
DUE TO			
(C) <i>Pericarditis - Hydrothorax</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at 1 ²⁰ PM, from the causes and on the date stated above.			
SIGNATURE <i>Leon L. Gallin</i>		ADDRESS DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5/5/1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 4 1955</i>		REGISTRAR'S SIGNATURE <i>Amanda Droney</i>	
24. FUNERAL DIRECTOR <i>Funeral Home, Inc.</i>		ADDRESS <i>3200 R. & Ave. Mt. Rainier, Md.</i>	

BUREAU V. S.

MAY 10 1955

RECEIVED

4935

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 04913

No. 242

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince George's	MARYLAND	STATE Maryland	COUNTY Prince George's
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Silver Hill	LENGTH OF STAY (In this place) 7 years	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Silver Hill	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4424 St. Barnabas Road		STREET ADDRESS (If rural, give location) 4424 St. Barnabas Road	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) James	(Middle) Arthur	(Last) Lusby	(Month) May (Day) 30 (Year) 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: 2/24/83
9. AGE last birthday: 72 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, specify if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY: Retired	
11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: James E. Lusby		14. MOTHER'S MAIDEN NAME: Olivia Sophia Preston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No.: 32 Mayer Drive	
17. INFORMANT & ADDRESS: Newell Lusby		Suffern, N. Y.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
420.1 Immediate cause (a)..... Coronary thrombosis DUE TO Antecedent cause(s) (b)..... Cardiovascular renal disease Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>James D. Jones</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/30/55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	5/1/1955	Washington Natl	Suitland Md
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 30-1955	<i>Edna F. Jones</i>	John A. Mattingly	131-112 St E Wash DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1965

BUREAU V. S.

04914

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 442

4936

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY G.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6506 Marlboro Pike S.E.		STREET ADDRESS (If rural, give location) 6506 Marlboro Pike S.E.	
3. NAME OF DECEASED (Type or Print)	(First) Henry (Middle) Werner (Last) Maske	4. DATE OF DEATH	(Month) 5 (Day) 19 (Year) 55
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) divorced	8. DATE OF BIRTH 10/20/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Truck	9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Maske		14. MOTHER'S MAIDEN NAME Henrietta Zutez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Justina Webber, same address			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
703.0 Immediate cause	(a) Hypostatic pneumonia	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Uremia	
	(c) Poison ivy dermatitis	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 12, 1955, to May 19, 1955, that I last saw the deceased alive on May 19, 1955 and that death occurred at 9:20 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James J. Boyd

M. D. Forestville, Md.

5/19/55

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5-23-55	NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	LOCATION (City, town, or county) Forestville, Maryland	(State)
DATE REC'D BY LOCAL REG. May 20, 1955	REGISTRAR'S SIGNATURE Carrie Campbell	24. FUNERAL DIRECTOR W.W. Chambers Co. Washington, D.C.	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3.

MAY 27 1935

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04915

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George		MARYLAND		STATE Maryland		COUNTY Prince George	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN Suitland		4 mos		TOWN Suitland X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 Suitland Rest Home				4500 Suitland Rd.,			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) RICHARD F. MCCORMICK				OF May 15, 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
Male		White		Single		January 6, 1874	
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):		11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
81 yrs.		Washington, D.C.		U.S.A.		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
Retired				Grocery Store			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Patrick McCormick				Bridgett McAllister			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
X No				---			
17. INFORMANT & ADDRESS:				700 N. Car. Ave., S.E. - Wash, DC			
Margaret M. McCormick							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE							
(A) Arteriosclerotic heart disease							
ANTECEDENT CAUSE (B)							
Chol. duct neoplasm							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 1, 1955, to May 15, 1955, that I last saw the deceased alive on May 14, 1955, and that death occurred at 6:25 M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
C. Beane Brown		M. D. 301-B NE		5/15/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 18, 1955		Mt. Olivet Cemetery		Washington, D.C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 16, 1955		Edna F. Solinas		J. H. G. G. G. G.		317 Penna. Ave., S.E.	

BUREAU V. S.

MAY 23 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

231

4979

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u>	MARYLAND <u>Dist</u>	STATE <u>Wash</u>	COUNTY <u>D.C.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Md</u>	LENGTH OF STAY (in this place) <u>4 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
38 TOWN <u>Chesley Md</u>		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82601 Chesapeake</u>		STREET ADDRESS (If rural, give location) <u>815 Buchanan St. N.W.</u>	
90 <u>Sacorda Crest Home</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JULIA LOUISE McGinness</u>		DEATH: <u>MAY 10 1955</u>	
5. SEX: <u>FE</u>	6. COLOR OR RACE: <u>WH</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>WIDOWED</u>	8. DATE OF BIRTH: <u>APRIL 26, 1893</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Edw. S. O'CONNOR</u>		14. MOTHER'S MAIDEN NAME: <u>MARY HERBERT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>JOHN MCGINNESS</u> <u>808 - 1722 - 19 W.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>PULMONARY CONGESTION</u>			<u>1 mo.</u>
ANTECEDENT CAUSE (B) <u>CORONARY SCLEROSIS</u>			<u>YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF "INJURY" <u>—</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>Nov. 1954</u> , to <u>MAY 10, 1955</u> , that I last saw the deceased alive on <u>MAY 10, 1955</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Paul Taylor MD</u>		DATE SIGNED <u>5-10-55</u>	
ADDRESS <u>Pa. Am. Wash, D.C.</u>		M.D. <u>2 140 Pa. Am. Wash, D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/13/55</u>	
NAME OF CEMETERY OR REMOVAL <u>Int. Union Cem.</u>		LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>Arnold Dorney</u>	
24. FUNERAL DIRECTOR <u>P. Daffell</u>		ADDRESS <u>475 H-S N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04917

CERTIFICATE OF DEATH

Reg. Dist. No. 242

4938

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince George</i> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Temple Hills</i>		STATE <i>Maryland</i> COUNTY <i>Prince George</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Temple Hills</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) <i>25 yrs</i>		STREET ADDRESS (If rural give location) <i>4941-Temple Hill Road</i>		1 S.E.	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>EULALIE MAY MEYERS</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>May 27th 1955</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH: <i>Jan 15-1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>domestic</i>		11. BIRTHPLACE (State or foreign country): <i>Fort Forté Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Albert A. Prevost</i>				14. MOTHER'S MAIDEN NAME: <i>Louisa Dunnington</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>William T. Meyers 4941-Temple Hill Rd</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Crownary thrombosis & myocardial infarction</i>						<i>1 week</i>	
ANTECEDENT CAUSE (B) <i>Diabetes mellitus</i>						<i>8 yrs.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Central embolus</i>						<i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1948</i> , 19... to <i>5-27</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5-27</i> , 19 <i>55</i> , and that death occurred at <i>11:40</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>John R. D. Smith</i>				ADDRESS <i>4223 Silver Hill Rd</i>		DATE SIGNED <i>5-27-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 30-1955</i>		NAME OF CEMETERY OR CREMATORY <i>St Barnabas</i>		LOCATION (City, town, or county) (State) <i>Temple Hill Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 29-55</i>		REGISTRAR'S SIGNATURE <i>Edna F. Sollins</i>		24. FUNERAL DIRECTOR <i>Sumner Bros</i>		ADDRESS <i>1661 Gourd Stope Rd</i>	

John P. D'Angelo

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04918

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE D. C. COUNTY -			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Glenn Dale (rural)		6 mos & 26 days.		TOWN Washington 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
08 Glenn Dale Hospital				3721 S. Dakota Ave., N. E. ✓			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)			
Milton		T. Moore		May 27 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	Widowed	11/20/1890	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Truck driver		Fred Drew Construction Co.		Fairfax, Va.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Edward Moore				Alice Morris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
4 No		Unknown		Decedent			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Myocardial Infarction						1 mo.	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
1002X (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.						7 mo	
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: Pulmonary tuberculosis - military						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from November 1954, to May 27, 1955, that I last saw the deceased alive on May 27, 1955, and that death occurred at 6:05 A.M., from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
Daniel R. Pinecone		M.D.		Glenn Dale Hospital		5/27/55	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5/31/55		Cedar Hill		Suitland Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5/27/55		A. L. Green		P. J. Raffell		Washington D.C.	

RECEIVED

JUN 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04919
Reg. Dist.

No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>38 Cheverly</i>		LENGTH OF STAY (on this place) <i>DDA</i>		CITY (If outside corporate limits write RURAL and give nearest town) <i>33 Bladensburg</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>99 Prince Georges Gen. Hosp</i>				STREET ADDRESS (If rural, give location) <i>5432 - Macbeth Street</i>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <i>Sammy Blake Murphy</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>5-8-55</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>8-1-1954</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: (If UNDER 1 YEAR) (Months) (Days) <i>4 yrs.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>William C. Murphy, Jr.</i>				14. MOTHER'S MAIDEN NAME: <i>Mable Margaret Foster</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mother - Same</i>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <i>Asphyxia</i>					
DUE TO					
Antecedent cause(s) (b) <i>Strangulation</i>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Home</i>		21c. (City or town) (County) (State) <i>Bladensburg - P. Sec 16 md</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5-8-55 - 8:00 M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Fell from crib. No impediment between mother & frame</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>John W. Maloney (Hyattsville md)</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>5-8-55</i>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>		DATE THEREOF <i>5-10-55</i>		NAME OF CEMETERY OR CREMATORY <i>W.D. Church Cemetery</i>	
LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>		24. FUNERAL DIRECTOR <i>J. Lavelle Sons, Hyattsville, md.</i>			
DATE REC'D BY LOCAL REG. <i>5/10/55</i>		REGISTRAR'S SIGNATURE <i>Amanda D. Doney</i>			

2084287417

RECEIVED
MAY 12 1955
BUREAU V. S.

4884

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

COUNTY Prince George MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville
 OR TOWN 4 yrs
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 725 Sheridan st.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Prince George
 CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville
 OR TOWN 15
 STREET ADDRESS (If rural give location) 725 Sheridan st.

3. NAME OF DECEASED:

(First) Erich (Middle) Willy (Last) Mrozek
 (Type or Print)

4. DATE OF DEATH:

(Month) 5 (Day) 3 (Year) 1955

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married Dec 10-1894

8. DATE OF BIRTH:

60 yrs.

9. AGE last birthday:

60 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Capt. of Waiters

10b. KIND OF BUSINESS OR INDUSTRY:

Shorham Hotel

11. BIRTHPLACE (State or foreign country):

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

UNKNOWN

14. MOTHER'S MAIDEN NAME:

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

4 No

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Annie E. Mrozek 725 Sheridan St. Hyattsville Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
 Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Non-occlusion
Arteriosclerosis

Interval Between Onset And Death

50 min.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

0

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

—

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

—

(CITY OR TOWN)

—

(COUNTY)

—

(STATE)

—

TIME (Month) (Day) (Year) (Hour) OF INJURY

—

INJURY OCCURRED

While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR ?

—

22. I hereby certify that I attended the deceased from May, 1947, to May, 1955, that I last saw the deceased alive on 3 May, 1955, and that death occurred at 5:10 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

—

DATE THEREOF

5/5/55

NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

LOCATION (City, town, or county) (State)

Prince Georges Co. Md.

DATE REC'D BY LOCAL REGISTRAR

5/3/55

REGISTRAR'S SIGNATURE

—

24. FUNERAL DIRECTOR

—

ADDRESS

S. D. Harris Co. 2901-14th St. N.W. Wash. D.C.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 9 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04921

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>PRINCE GEORGE</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TUXEDO</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>TUXEDO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5904 ARBOR ST.</u>				STREET ADDRESS (If rural give location) <u>5904 ARBOR ST.</u>			
3. NAME OF DECEASED: (First) <u>JUANA</u> (Middle) <u>NIEVES</u> (Last) <u>NIEVES</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 26 19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>11/8/1889</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 24 HRS.: Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>SAN JUAN PUERTO RICO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>SECUNDINO RODRIGUEZ</u>				14. MOTHER'S MAIDEN NAME: <u>MARTINA ALICEA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS: <u>MARIA ROY (DAUGHTER) 5904 ARBOR ST. TUXEDO, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>3 YRS</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? _____		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19 <u>48</u> , to <u>MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/25</u> , 19 <u>55</u> , and that death occurred at <u>4:00A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph C. Lawling Jr.</u>				M. D. <u>6124 CENTRAL AVE. CAPT. HETS</u> DATE SIGNED <u>5/26/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-28/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/26/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>		ADDRESS <u>131-11-24 SE Wash DC</u>	

RECEIVED
MAY 31 1955
BUREAU V. S.

4911

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>	STATE <i>Maryland</i> COUNTY <i>Prince George</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Seat Pleasant</i>
38 TOWN	LENGTH OF STAY (in this place) <i>7 days</i>	STREET ADDRESS (If rural give location) <i>69 Addison Rd</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Geo. Gen Hosp</i>		1	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Stephen (N.M.M.) Noll</i>		DEATH: <i>May 15 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Nov. 18/1885</i>
9. AGE last birthday <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Barber - Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>SELF-EMPLOYED</i>	
11. BIRTHPLACE (State of foreign country): <i>Hungary -</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>GEORGE NOLL</i>		14. MOTHER'S MAIDEN NAME: <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	
17. INFORMANT & ADDRESS: <i>ELIZABETH NOLL - 69 ADDISON ROAD SEAT PLEASANT MD</i>		INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
572.1 IMMEDIATE CAUSE			
(A) DUE TO <i>Diffuse Peritonitis</i>			
ANTECEDENT CAUSE (S):			
(B) DUE TO <i>Perf Sigmoid Ulceration</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Alcoholism & Left Atrial Fibr.</i>			
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 7</i> , 19 <i>55</i> to <i>May 15</i> , 19 <i>55</i> that I last saw the deceased alive on <i>May 15</i> , 19 <i>55</i> , and that death occurred at <i>2:40 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>William Brown</i>		DATE SIGNED <i>M.D. 6124 Central Ave, Capitol Hill Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>5/18/1955</i>	
NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL Cem.</i>		LOCATION (City, town, or county) (State) <i>Saunder P. Co. Co. Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/16/55</i>		REGISTRAR'S SIGNATURE <i>Amanda Downey</i>	
24. FUNERAL DIRECTOR <i>W. W. CHAMBERS Co - Riverdale Md</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1966

BUREAU W. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04923

4912

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince George's</i> MARYLAND				STATE <i>Maryland</i> COUNTY <i>P. George</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesley, Maryland</i>				CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville, Md.</i>			
TOWN <i>Chesley, Maryland</i>				TOWN <i>Hyattsville, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Geo. Co. Hosp.</i>				STREET ADDRESS (If rural give location) <i>3910 Oneida Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Marlin Osborn</i>				<i>May 20, 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>April 16, 1906</i>	9. AGE last birthday <i>49</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Chief of Police in</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>U.S. Government</i>		11. BIRTHPLACE (State or foreign country): <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>Orlo Osborn</i>				14. MOTHER'S MAIDEN NAME: <i>Minnie Bell Allen</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Hospital, Oneida Chesley, Md</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4200							
IMMEDIATE CAUSE							
(A) <i>Cerebral Thrombosis</i>							
DUE TO							
ANTECEDENT CAUSE (S):							
(B) <i>Chronic Ischemic Heart Disease</i>							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5/19, 1955</i> to <i>5/20, 1955</i> , that I last saw the deceased alive on <i>5/19, 1955</i> , and that death occurred at <i>1:45</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>Alfred E. Egan</i>				DATE SIGNED <i>May 20, 1955</i>			
M. D. <i>College Park, Md.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Interment</i>		<i>May 22, 1955</i>		<i>Indianapolis</i>		<i>Indiana</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>May 22, 1955</i>		<i>Armanda Draney</i>		<i>George's sons</i>		<i>Hyattsville, Md</i>	

BUREAU V. S.

MAY 24 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4941

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

Items 11 12 File 6181 5-10-55 at

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Switland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest Heights</u>	
TOWN <u>Switland</u>		TOWN <u>Hill Crest Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5400 Switland Road</u>		STREET ADDRESS (If rural, give location) <u>2212 - Cherson ST S.E.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ANNA</u> (Middle) <u>C.</u> (Last) <u>PETERSON</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 8 - 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u>	
13. FATHER'S NAME <u>Alfred Werme</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Edward A. Peterson 2212 - Cherson ST S.E.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a) Coronary occlusion A.M.D

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) generalized arteriosclerosis

10 yrs

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to May 10, 1955, that I last saw the deceasedalive on May 4, 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 10 - 55Edward F. GillmanSummons Bros. Wash DC1661 - Good Hope Rd SE

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 8, Film G183, 6/30/55 rcy		04925	
4913 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 231			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince George's	MARYLAND	STATE Maryland	COUNTY P. Geo
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cheverly	LENGTH OF STAY (in this place) 14 hrs	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sandover Hills	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Gen. Hosp		STREET ADDRESS (If rural, give location) 6816 Annapolis Rd.	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Martha Ellen	(Middle) Powell	(Last)	5-17-1953
5. SEX: Female		6. COLOR OR RACE: White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 12-1-1915	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): N. Carolina		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: Allen Douglas Powell		14. MOTHER'S MAIDEN NAME: Jacqueline O'Hanlon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: Jacqueline Powell Sandover Hills, Md			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Intra cranial hemorrhage & shock			
Antecedent cause(s) (b) Multiple cerebral lacerations & contusions.			
(c) Fractured skull.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 5-16-55			
19b. MAJOR FINDING OF OPERATION: Fractured skull - subdural hemorrhages			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY) Sandover Hills, Md	
21c. CITY or town (County) Sandover Hills, Md			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 5-16-55 140 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? Struck by automobile.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE John W. Maloney (Hyattsville, Md)			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-18-55			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF May 20, 55	
NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		LOCATION (City, town, or county) Washington D.C.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 5/19/55 Amanda Downey		24. FUNERAL DIRECTOR 7 Gasch's sons Hyattsville Md	
ADDRESS			

RECEIVED

MAY 23 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04925

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 TOWN <i>Chesley</i>		<i>3 days</i>		<i>Clinton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <i>Prince Georges General Hosp.</i>				<i>1</i>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH: 5 10 19 55	
<i>Male</i>		<i>Proctor</i>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>Negro</i>	<i>Single</i>	<i>5-8-55</i>	<i>—</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<i>Maryland.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>James Proctor</i>				<i>Senecioe Proctor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
		<i>-</i>		<i>James Proctor Clinton, md</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
7544 IMMEDIATE CAUSE (A) <i>Congenital Heart disease</i>							
ANTECEDENT CAUSE (S) (B) <i>Acute Cardiac collapse</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/8</i> , 19 <i>55</i> , to <i>5/16</i> , 19 <i>55</i> ; that I last saw the deceased alive on <i>5/10</i> , 19 <i>55</i> , and that death occurred at <i>8:40</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>J. A. Christensen</i>				M. D. <i>College Park</i>		DATE SIGNED <i>5/16/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>5/13/55</i>		<i>St Johns</i>		<i>Clinton md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>May 16, 1955</i>		<i>Amanda Dawney</i>		<i>Huntt & Ryon</i>		<i>Waldorf, md</i>	
<i>2055265304</i>							

BUREAU V. S.

MAY 17 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4942 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04927
Reg. Dist.

No. 232

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George's		MARYLAND		STATE Maryland		COUNTY Prince George's	
CITY (If outside corporate limits write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN Upper Marlboro		Days		TOWN Upper Marlboro			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 30,				STREET ADDRESS (If rural, give location) Rt 301			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) William Louis				(Month) May 15 1955			
(Middle) Proctor				(Last)			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH: Sept 4, 1904	9. AGE last birthday: 50 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): Farmer (Tobacco)	10b. KIND OF BUSINESS OR INDUSTRY: Tenant	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? P. J.				
13. FATHER'S NAME: William Proctor				14. MOTHER'S MAIDEN NAME: Ida			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Elizabeth Proctor, same address			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
4201 Immediate cause (a) Coronary occlusion							
DUE TO Antecedent cause(s) (b) Cardiovascular renal disease							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE James H. Ford		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-15-55		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 5/18/55		NAME OF CEMETERY OR CREMATORY St. John's Catholic		LOCATION (City, town, or county) (State) Clinton Maryland.	
DATE REC'D BY LOCAL REG. May 17 1955		REGISTRAR'S SIGNATURE John F. Danner.		24. FUNERAL DIRECTOR Ritchie Bros.		ADDRESS Upper Marlboro, Md.	

RECEIVED

MAY 20 1955

BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: Prince George		2. USUAL RESIDENCE (HOME) OF DECEASED: Prince Georges	
COUNTY	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN Cottage City	26 yrs	TOWN Cottage City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3712 Parkwood Street		STREET ADDRESS (If rural give location) 3712 Parkwood Street	
3. NAME OF DECEASED: (First) Charles (Middle) Edwin (Last) Pumphrey		4. DATE OF DEATH: (Month) May (Dry) 23 (Year) 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: Sept. 5, 1875
9. AGE last birthday: 79 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Carpenters		10b. KIND OF BUSINESS OR INDUSTRY: Self	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: James T. Pumphrey		14. MOTHER'S MAIDEN NAME: Elizabeth Harvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 214-12-7359	17. INFORMANT & ADDRESS: Edwin Deavers- Cottage City, Md.

18. MEDICAL CERTIFICATION		Interval Between
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Onset And Death
420.0 Immediate cause	(a) Arteriosclerotic Heart & Kidney Disease	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last.</u>	(b) Parkinsonian Disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.												
19a. DATE OF OPERATION:					19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE		(Specify)			PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			HOW DID INJURY OCCUR ?							

22. I hereby certify that I attended the deceased from Jan 1, 1955, to May 28, 1955, that I last saw the deceased alive on 5/23, 1955, and that death occurred at _____, from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/26/55	Cedar Hill Cemetery	Suitland, Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/29/55	Amanda Downey	Francis Gasch's Sons, Hyattsville, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 26 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4915

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 Reg. Dist. 04029
 No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Prince Geo.</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Chesley</u>		<u>20.0.0.</u>		TOWN <u>mt Rainier</u>		<u>16</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>3706 - Shepherd street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Norman M. Cloud Reed</u>				<u>5 - 26 - 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1-29-86</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Refrigeration Mechanic</u>		<u>Auto. repair</u>		<u>S. Carolina</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Laurie Jolly Reed</u>				<u>Katie Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>3 No</u>				<u>220-26-4407</u>		<u>Elizabeth Haddock - Hyattsville, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute congestive heart failure</u> DUE TO Antecedent cause(s) (b) <u>Cardiovascular renal disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John J. Maloney (Hyattsville, Md.)</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-26-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 31, 1955</u>		<u>Cedar Hill</u>		<u>Switzland Md</u>	
DATE REC'D BY LOCAL REG:		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8/29/55</u>		<u>Amanda Journey</u>		<u>F. Gaschi Sore</u>		<u>Hyattsville, Md</u>	

BUREAU V. S.

JUN 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04930 248

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> OR TOWN <u>9 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deland memorial Hosp.</u>				STATE <u>md</u> COUNTY <u>Prince Geo</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u> - <u>md</u> OR TOWN <u>2207 Hannon St</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <u>William</u> (First) <u>6</u> (Middle) <u>Riedel</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>5-21</u> 19 <u>55</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>wid</u>	8. DATE OF BIRTH: <u>5-22-81</u>	9. AGE last birthday: <u>73</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>General accounting</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country): <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William S. Riedel</u>				14. MOTHER'S MAIDEN NAME: <u>L. Kromer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Kathryn Riedel (Daughter)</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>1 week</u>	
ANTECEDENT CAUSE (S) <u>General Arteriosclerosis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>General Arteriosclerosis</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21G. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1955</u> , to <u>May 21, 1955</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>55</u> , and that death occurred at <u>6:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L W Nealer</u>				DATE SIGNED <u>5-21-55</u>			
M. D. <u>Riversdale, md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Home Cemetery</u>		LOCATION (City, town, or county) (State) <u>Ballastown, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>		FEDERAL DIRECTOR <u>Gascha son Hyattsville Md.</u>		ADDRESS	

RECEIVED

MAY 27 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4944

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04931

CERTIFICATE OF DEATH

Reg. Dist. No. 283

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Glenn Dale (RURAL)		7 mo., 18 days		TOWN Washington 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital				STREET ADDRESS (If rural, give location)			
1744 Florida Ave., N.W.							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)		5. SEX: Male		6. COLOR OR RACE: Negro	
ARTHUR		ROACHE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) *widowed		8. DATE OF BIRTH: 12/18/77	
9. AGE last birthday: 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter		11. BIRTHPLACE (State or foreign country): Natural Bridge, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Newman Roache				14. MOTHER'S MAIDEN NAME: Sallie Ross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
4 no		?		Decedent			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
332X Immediate cause (a) Left Cerebral Thrombosis, middle cerebral artery						5 days	
Antecedent cause(s) (b) Cerebral Arteriosclerosis						unknown	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.						10 months	
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: Pulmonary Tuberculosis						20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-6, 1954, to 5-24, 1955, that I last saw the deceased alive on 5-24, 1955, and that death occurred at 3:30 p.m., from the causes and on the date stated above.							
SIGNATURE Daniel Leo Amiceno M.D.				ADDRESS Glenn Dale Hospital, Glenn Dale, MD		DATE SIGNED 5/24/55	
23. BURIAL, CREMATION REMOVAL (Specify): Removal		DATE THEREOF 5/26/55		NAME OF CEMETERY OR CREMATORY -		LOCATION (City, town, or county) (State) Washington D.C.	
DATE REC'D BY LOCAL REG. 5/24/55		REGISTRAR'S SIGNATURE W. Ernest Jarvis Co		24. FUNERAL DIRECTOR ADDRESS Washington D.C.			

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 Reg. Dist. **04932**
 No. **231**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George's		MARYLAND		STATE Maryland		COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN Cheverly		Dead on arrival		TOWN Croome		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince George's Gen'l Hosp.				STREET ADDRESS (If rural, give location) /			
3. NAME OF DECEASED: (Type or Print)		(First) Carroll		(Middle) Marie		(Last) Robinson	
5. SEX: Female		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH: March 1, 1954	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or retired): None		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: 1 yrs.		4. DATE OF DEATH: (Month) 5 (Day) 29 (Year) 19 55	
11. BIRTHPLACE (State or foreign country): Maryland				12. CITIZEN OF WHAT COUNTRY: U.S.A.			
13. FATHER'S NAME: Luzon Robinson				14. MOTHER'S MAIDEN NAME: Grace West			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Luzon Robinson, Croome, Md.			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Congestive heart failure							
DUE TO							
Antecedent cause(s) (b) Bronchopneumonia							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE James D. Boush		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED 5/30/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 6-1-55		NAME OF CEMETERY OR CREMATORY Hillman Cemetery		LOCATION (City, town, or county) (State) Brandenburg Md	
DATE REC'D BY LOCAL REG. 6-1-55		REGISTRAR'S SIGNATURE M. B. Mours		24. FUNERAL DIRECTOR Hunt & Ryan		ADDRESS Waldorf Md	
Annanda Downey							

BUREAU V. 2

JUN 3 1955

RECEIVED

4918

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>	STATE <i>md.</i> COUNTY <i>Pr. Ge.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>
TOWN <i>Chesley</i>	LENGTH OF STAY (in this place) <i>7 hrs.</i>	OR TOWN <i>College Park</i>	14
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Geo. Gen. Hospital</i>	STREET ADDRESS (If rural give location) <i>4409 Usange St.</i>		
3. NAME OF DECEASED: (First) <i>Kenneth</i> (Middle) <i>Schiavone</i> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <i>May 8</i> 19 <i>55</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>—</i>	8. DATE OF BIRTH: <i>5.13.54.</i>
9. AGE last birthday <i>11</i> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>John schiavone</i>		14. MOTHER'S MAIDEN NAME: <i>Ethel Colwell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS: <i>Hospital Records, Chesley Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>525X</i>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) DUE TO <i>Interstitial Pneumonitis</i>			<i>24 hrs.</i>
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hyperpyrexia</i>			<i>9 hrs.</i>
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1-10</i> , 19 <i>55</i> , to <i>5-8</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5-8</i> , 19 <i>55</i> , and that death occurred at <i>6⁰⁰</i> AM, from the causes and on the date stated above.			
SIGNATURE <i>Ben H. McNeill</i>		DATE SIGNED <i>5-8-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-10-55</i>	
NAME OF CEMETERY OR CREMATORY <i>George Washington</i>		LOCATION (City, town, or county) (State) <i>Hyattsville, Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>8/15/55</i>		REGISTRAR'S SIGNATURE <i>Amanda Downey</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>7 Lincoln St Hyattsville, Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 13 1965

RECEIVED

4919

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04934
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 231

1. PLACE OF DEATH:

COUNTY Prince Georges MARYLANDCITY (If outside corporate limits write RURAL and give nearest town) Chesley TOWN Chesley LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Gen Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Prince GeorgesCITY (If outside corporate limits write RURAL and give nearest town) Langham TOWN XSTREET ADDRESS (If rural give location) 6708 Auburn Avenue

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

Oct. 30, 1909

4. DATE OF DEATH

5 - 6

(Month) (Day) (Year)

19 55

9. AGE last birthday:

43 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Watchman

10b. KIND OF BUSINESS OR INDUSTRY:

Lumber

11. BIRTHPLACE (State or foreign country):

W. Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

George Albin Sorvco

14. MOTHER'S MAIDEN NAME:

Lola B. Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

9

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Gertrude Mae Sorvco Same address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyaltonville, Md) (6-2-55)

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED

5-6-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

5/9/55

NAME OF CEMETERY OR CREMATOR

Cedar Hill

LOCATION (City, town, or county)

Charles Town W. Va.

(State)

DATE REC'D BY LOCAL REG.

5/6/55

REGISTRAR'S SIGNATURE

Amanda Sorey

24. FUNERAL DIRECTOR

Hypocryt Funeral Home

ADDRESS

1300 N - 4th NW Washington DC

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6089

RECEIVED

MAY 11 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-especially. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 04935

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George's MARYLAND				STATE D.C. COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Suitland				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suitland Parkway				STREET ADDRESS (If rural, give location) 607 6th Street S.W.			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		Eli, abeth Matilda Sheaffer		May 4		1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Separately	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White		4/14/23	32 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, Food Handler				10b. KIND OF BUSINESS OR INDUSTRY: Meat Packing		11. BIRTHPLACE (State or foreign country): Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME: George Edward Sheaffer				14. MOTHER'S MAIDEN NAME: Virginia Hale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.: 579-20-8823		17. INFORMANT & ADDRESS: Margaret Josephine Sheaffer	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
795.3 Immediate cause (a) Natural causes, undetermined					
DUE TO					
Antecedent cause(s) (b) (Body found badly decomposed - last seen alive 2-17-55)					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: 2				19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE James J. Boyle		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/6/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 5/6/55		NAME OF CEMETERY OR CREMATORY Pr. Geo Co. Alms Hs. Cem.	
LOCATION (City, town, or county) Ritchie		(State) Md.			
DATE REC'D BY LOCAL REG. May 8, 1955		REGISTRAR'S SIGNATURE Carrie Campbell		24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.	

RECEIVED MAY 11 1955

UNITED STATES DEPARTMENT OF HEALTH
NATIONAL BUREAU OF VITAL STATISTICS
FEDERAL BUREAU OF INVESTIGATION

NAME		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		RACE	
MARRIAGE		EDUCATION		OCCUPATION	
RELIGION		SOCIETY		MILITARY SERVICE	
CIVIL SERVICE		JUDICIAL SERVICE		OTHER SERVICE	
REMARKS		SIGNATURE		DATE	

RECEIVED
MAY 11 1955
BUREAU V. S.

4946

04936

Reg. Dist.

Item 21 Film 101 5-10-55 am

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 230

1. PLACE OF DEATH:

COUNTY Prince Georges MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Berwyn
 TOWN Berwyn LENGTH OF STAY (in this place) 5 yrs
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 8608 Baltimore Boul

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Prince Georges
 CITY (If outside corporate limits write RURAL and give nearest town) Berwyn - Collige Park
 TOWN Berwyn - Collige Park
 STREET ADDRESS (If rural, give location) 8608 Baltimore Boulevard

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) Andrew Clinton Slomp

4. DATE OF DEATH

(Month)

(Day)

(Year)

May 1 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

860X
 Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

John W. Slomp (Hyattsville Md)

M. D.

DEPUTY MEDICAL EXAMINER

5-1-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 3 1955

John D. Smith

B. Sachs Sons

Hyattsville, Md.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4920 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, see Birth Cert.

04937

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 TOWN <u>Charles</u>		7 days		<u>Contee</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <u>Prince Georges Hosp.</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Eastern</u> <u>Smith</u> <u>Twin I</u>				DEATH: <u>5-16</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
<u>7</u>	<u>C</u>		<u>4/21/55</u>		<u>26</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>md</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Earl Smith</u>				<u>Bernice Pearson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Multiple military lung abscesses</u>							<u>1 week</u>
ANTECEDENT CAUSE (B) <u>Branchopneumonia, bilateral</u>							<u>1 week.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Aspiration?</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/16</u> , 19 <u>55</u> , to <u>5/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/16</u> , 19 <u>55</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>J. W. Palmer</u>		<u>5501 Hamilton St, Hyattsville Md</u>		<u>5/17/55</u>			
23. BURIAL - CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>may 19, 1955</u>		<u>Charlesville Md</u>		<u>Forest Hope Md</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/17/55</u>		<u>Amanda Dourney</u>		<u>Robert D. Snowden</u>		<u>Rossville Md</u>	

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CHRYSLER FINANCIAL CORP.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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BUREAU V. 2

MAY 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04938

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 242

1. PLACE OF DEATH:

COUNTY

Prince Georges

MARYLAND

CITY (If outside corporate limits, write OR and give nearest town)

TOWN

Highland Park

LENGTH OF STAY (in this place)

6 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

1114-70th Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Prince Georges

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Highland Park

STREET ADDRESS

(If rural, give location)

111470th Ave

3. NAME OF DECEASED:

(Type or Print)

(First)

Lama

(Middle)

Virginia

(Last)

Smith

4. DATE OF DEATH

(Month)

(Day)

(Year)

5-3-1955

5. SEX:

Female

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED

(Specify): Married

8. DATE OF BIRTH:

Oct-15-1875

9. AGE last birthday:

79 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

House-wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Daniel Henderson

14. MOTHER'S MAIDEN NAME:

Jane Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Samuel Duncan - 1207-70th Ave -

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

acute congestive heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Cardiovascular renal disease

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Arteriosclerosis -

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyattsville, Md.)

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

5-3-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

5-7-55

NAME OF CEMETERY OR CREMATORY

Mt. Olivet

LOCATION (City, town, or county)

Wash. D.C.

(State)

DATE REC'D BY LOCAL REG.

May 3-1955

REGISTRAR'S SIGNATURE

Carrie F. Campbell

24. FUNERAL DIRECTOR

H. S. Washington - Sons

ADDRESS

467 N St. N.W.

Wash. D.C.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED MAY 6 1955

RECEIVED MAY 6 1955

BUREAU V. S.

MAY 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04939

4921

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>P. Geo. Co.</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>P. Geo. Co.</i>	
CITY (If outside corporate limits, write RURAL OR nearest town) <i>Bladensburg</i>		LENGTH OF STAY (in this place) <i>75 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bladensburg</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>4908 Upshur St.</i>				STREET ADDRESS (If rural give location) <i>4908 Upshur St.</i>		1	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Lena Estella Snell</i>				<i>5 20 1955</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH: <i>16 Jan 1873</i>	9. AGE last birthday <i>82</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	11. BIRTHPLACE (State or foreign country): <i>md.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John Snell</i>				14. MOTHER'S MAIDEN NAME: <i>Mary ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Lillian Wellbourne 122</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>422.2</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>Cardiac insufficiency</i>						<i>1 mo</i>	
DUE TO							
(B) <i>High blood pressure</i>						<i>3 yrs</i>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Spartic</i>						<i>82 yrs</i>	
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 15 55</i> , 19 <i>55</i> to <i>May 20 55</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>May 18 55</i> , 19 <i>55</i> , and that death occurred at <i>9:20 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>W. S. Hudson</i>		M.D.		ADDRESS <i>Laurel md</i>		DATE SIGNED <i>5-21-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-24-55</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		LOCATION (City, town, or county) (State) <i>N.E. Washington D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/22/55</i>		REGISTRAR'S SIGNATURE <i>Armando Doney</i>		24. FUNERAL DIRECTOR <i>Funeral Home S. R. St. N.W.</i>		ADDRESS <i>Washington D.C.</i>	

BUREAU V. S.

MAY 24 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4890

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04940

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Lokoma Park Md</u>	STATE <u>Md.</u> COUNTY <u>Prince Georges</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>East Riverdale, Md</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sligo Mill, Rd</u>		STREET ADDRESS (If rural, give location) <u>6221- 61st Place</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>John</u> (Middle) <u>Henry</u> (Last) <u>Sullivan</u>		(Month) <u>5</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan 14, 1888</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>4</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Landscape Gardener - self</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>self</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>John Henry Sullivan</u>		14. MOTHER'S MAIDEN NAME: <u>Louisa Kendall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.: <u>577-26-7201</u>	
17. INFORMANT & ADDRESS: <u>Greg Sullivan - Seabrook, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>443X</u> <u>Slaughter in law</u>			
(b) Antecedent cause(s) <u>Chronic pulmonary edema</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>Constrictive heart failure</u>			
(d) <u>Hypertensive heart disease</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>5</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>John J. Maloney (Hyattsville, Md)</u>		M. D. <u>5-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 7, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>York Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 4 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jas. Lawrence</u>	
24. FUNERAL DIRECTOR <u>Arthur Waller</u>		ADDRESS <u>257 Carroll St NW</u>	

In 9.6039
(Mabel Vaughan)

Wm Agnes Louise Sullivan

BUREAU V. S.

MAY 9 1925

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

04941

4881

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 230

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY P. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN College Park		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN College Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4315 Rowalt Dr. Apt. 101		STREET ADDRESS (If rural, give location) 4315 Rowalt Dr. Apt. 101	
3. NAME OF DECEASED (Type or Print) NORVAL THOMAS SULLIVAN		4. DATE OF DEATH (Month) May (Day) 26 , (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Nov. 23, 1894
9. AGE last birthday 60 yrs.		10. If under 1 year: Months 1 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working day, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Norman Ford Co	
11. BIRTHPLACE (State or foreign country) Columbus Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alex Sullivan		14. MOTHER'S MAIDEN NAME Minnie Jane Clapp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 356-16-9531	
17. INFORMANT Mrs. L.M. Sullivan		4315 Rowalt Dr. College Park Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
157X Immediate cause (a) Exhaustion			
Antecedent cause(s) (b) Carcinomatosis			
(c) Carcinoma of pancreas			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE John J. Maloney (Hyattsville Md.) M.D.		DATE SIGNED May 26, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF May 31/1955	
NAME OF CEMETERY OR CREMATORY Go. Wash Cemetery		LOCATION (City, town, or county), (State) Riggs Rd Ext Hyattsville P.O., Md	
DATE REC'D BY LOCAL REG. May 27-1955		REGISTRAR'S SIGNATURE John D. Smith	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.		ADDRESS RIVERDALE MD.	

RECEIVED

MAY 31 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04942

Reg. Dist. No. 231

4922

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>38 TOWN Chertsey</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 TOWN Columbia Park (Hyattsville)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2601 Chertsey Ave.</u>				STREET ADDRESS (If rural, give location) <u>Linden Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>SARAH</u>		(First) <u>Eleanor</u>		(Last) <u>SULLIVAN</u>		4. DATE OF DEATH OF <u>MAY</u> (Month) <u>14</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 24, 1922</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Dant</u>				14. MOTHER'S MAIDEN NAME <u>Sarah (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>J. J. Sullivan - 4545 Conn Ave Washington</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <u>443X CARDIAC-RESPIRATORY FAILURE</u>							
Antecedent cause(s) <u>HYPERTENSIVE-CARDIO-VASC. DIS. CVA. 1 YEAR</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>GENERALIZED ARTERIOSCLEROSIS</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>SEPT. 54</u> , to <u>MAY 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>MAY 14</u> , 19 <u>55</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Max M. Herzberg</u>				(Degree or title) <u>M.D.</u>		ADDRESS <u>7016 GREIG ST. SEAT-PLASANT M.D.</u>	
DATE SIGNED <u>5-14-1955</u>							
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF <u>May 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>5/16/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - RIVERDALE, MD</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 19 1965

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04943

245

Reg. Dist. No.

4885

1. PLACE OF DEATH:

County Prig George Co.City or town 15 Hyattsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeksHospital, institution, or street address where death occurred:
00

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert Co.City or town Chesapeake 04X-2
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Agnes Elizabeth Taylor

3. (b) Social Security Number

194. Sex Female 5. Color or race negro 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Edward Taylor

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 18788. AGE: 76 Years 10 Months Days If less than one day hrs. min.9. Birthplace Calvert County, Md
(Town, county, and state)10. Usual occupation House wife11. Industry or business Home12. Name Steven Reed13. Birthplace Calvert County14. Maiden name Miller15. Birthplace Calvert County16. Informant Sarah ParrishAddress Hyattsville Md17. Burial Date thereof 0 25 1954
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory StedmanLocation Calvert Co18. Funeral director P. E. SewellAddress Prince Frederick Md19. James Sewell Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1955 at 7:05A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1955 to May 21 1955 and that I last saw her alive on May 18 1955Immediate cause of death cerebral hemorrhage DURATION 1 mo.Due to High blood pressure 4 yrsDue to 331X

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W S Hudson, M.D. M. D. or otherAddress Laurel Md Date signed May 31 1955

RECEIVED

MAY 23 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04944

4923

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Maryland</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>630 Main Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Evelyn R. Taylor</u>				<u>May 7, 1955</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
			<u>September 2, 1889</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>George Price</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Rhodes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>630 Main St. George D. Taylor, Laurel, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Hypertension</u>							
ANTECEDENT CAUSE (B) <u>Cerebral hemorrhage</u>							<u>2 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary artery disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>3-6-55</u> , 1955, to <u>May 7, 1955</u> , that I last saw the deceased alive on <u>5-7</u> , 1955, and that death occurred at <u>10 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. Bomer</u>			ADDRESS <u>Hyattsville, Md.</u>		DATE SIGNED <u>5-7-55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>May 10 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Balt. National Cem.</u> LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
DATE REC'D BY LOCAL REGISTRAR <u>May 9-55</u>			REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>De Witt Sanderson</u> ADDRESS <u>Laurel, Md.</u>		

RECEIVED

MAY 13 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04945 231...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Clinton</u>		STATE <u>Maryland</u> COUNTY <u>Pr. George's</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
38 TOWN <u>Clinton</u>		LENGTH OF STAY (In this place) <u>14 weeks</u>		STREET ADDRESS (If rural give location) <u>—</u>		1	
77 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's Juv. Hosp.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Henry FAIRFAX Tolson</u>				OF DEATH: <u>May 23</u> 19 <u>55</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>11/5/83</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <u>STATIONARY ENGINEER D.C. PUBLIC SCHOOLS</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>STAFFORD COUNTY, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>DANIEL TOLSON</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH BOTTS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give year or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>JEROME F. TOLSON-1007-46th St. N.E.</u>	
18. MEDICAL CERTIFICATION				INTERNAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Toxemia (Uremic) Diabetes</u>				<u>3 mo</u>			
(B) <u>Arterio sclerosis Longum leg</u>				<u>3 mo</u>			
(C) <u>Arterio sclerosis</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>55</u> to <u>5-21</u> , 19 <u>55</u> that I last saw the deceased alive on <u>5-20</u> , 19 <u>55</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James O. Watson</u>				ADDRESS <u>5304 Annapolis Rd</u>		DATE SIGNED <u>5-21-55</u>	
M.D. <u>Bladenburg, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/23/1955</u>		<u>Cedar Hill Cem.</u>		<u>Suitland, Pa. Co. G, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/21/55</u>		<u>James O. Watson</u>		<u>W.W. CHAMBERS Co. - Riverdale, Md.</u>			

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4925

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

Item 14 Film 182 6-17-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Geo. Co.</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheverly</u>	STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>W. Hyattsville</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen. Hosp.</u>	LENGTH OF STAY (in this place)	STREET ADDRESS (If rural give location)	<u>Thorp St.</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Baby Girl Tremblas</u>		DEATH: <u>May 31 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>31 May 55</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<u>45</u>		<u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Tremblas</u>		<u>Ernestine Patovillet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
<u>Hospital Cheverly, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>			<u>45 min</u>
ANTECEDENT CAUSE (S) (B) <u>Birth Trauma</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>9</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 31, 1955</u> , to <u>May 31, 1955</u> , that I last saw the deceased alive on <u>May 31, 1955</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Jordan W. Keller</u>		DATE SIGNED <u>6/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/2/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>7 Beech St Hyattsville, Md</u>	

2055432342

RECEIVED

JUN 7 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4948 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04947
Item 7, Film GL82 6-1-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH: <u>6413-Jay St</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>XAVRA ARUNN</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>P. Co.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hgts</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hgts</u>	
TOWN <u>Cedar Hgts</u>		TOWN <u>Cedar Hgts</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>6413-Jay St. n.e.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>LAURA JANE TRUITT</u>		<u>MAY 8 1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 19-1880</u>
9. AGE last birthday: <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOUSE WIFE</u>	
11. BIRTHPLACE (State or foreign country): <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Daniel Bryant</u>		14. MOTHER'S MAIDEN NAME: <u>Cornelia Bryant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>6409-Jay St n.e.</u>	
17. INFORMANT & ADDRESS: <u>6409-Jay St n.e.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
331X Immediate cause (a) <u>Orthostatic Pneumonia</u>		<u>2 days</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>cerebral accident =</u>		<u>3 mos</u>	
(c) <u>arteriosclerosis hemiplegia</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at Work Not While At Work	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr 4, 1955</u> , to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 8, 1955</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>John W. Pratt</u>		DATE SIGNED <u>May 8, 1955</u>	
(Degree or title) <u>M.D.</u>		ADDRESS <u>330-61st St. W.E.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>R</u>	<u>May 8/55</u>	<u>WOODLAWN</u>	<u>Wash. D.C.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 8, 1955</u>	<u>Carrie Campbell</u>	<u>H.S. WASHINGTON</u>	<u>467 N. S. TNK</u>

RECEIVED

MAY 11 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4949

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04948

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>Pr. Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Hillcrest Heights</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hillcrest Heights</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10				STREET ADDRESS (If rural give location) <u>5403-26th Ave</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>FANNY D Warren</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 18 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1-4-1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>ILL.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>JAMES M. VA WAGNER</u>				14. MOTHER'S MAIDEN NAME: <u>HARRITT JOHNSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. LaRue Warren</u> <u>5403-26th Ave. Hillcrest Heights Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>						<u>several yrs</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
M.							
22. I hereby certify that I attended the deceased from <u>June, 1940</u> , to <u>May 18, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W H Clements</u>				ADDRESS <u>M. D. 110 13th St SE. Wash.</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 21, 1955</u>		<u>Cedar Hill Cemetery</u>		<u>Smithland Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>May 14, 1955</u>		<u>Carrie Campbell</u>		<u>J W E Lee Box 300-42nd St. Wash. D.C.</u>			

BUREAU V. S.

MAY 23 1955

RECEIVED

4950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04949

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 242.....

1. PLACE OF DEATH:

COUNTY Prince George's MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Forestville

LENGTH OF STAY (in this place)

2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Brown Station Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY P. G.

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Croome

STREET ADDRESS

(If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Benjamin Franklin Washington

4. DATE OF DEATH

(Month)

(Day)

(Year)

May 12 1955

5. SEX:

male

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED.

Single

8. DATE OF BIRTH:

Sept 23, 1932

9. AGE last birthday:

22 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Janitor

11. BIRTHPLACE (State or foreign country):

Croome, Md

12. CITIZEN OF WHAT COUNTRY:

U. S. A

13. FATHER'S NAME:

Henry Washington

14. MOTHER'S MAIDEN NAME:

Mary Spriggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS

Mary Washington, Croome, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

Hemorrhage and shock

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

Stab wound of chest

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

May 12 1955

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office, etc., INJURY)

Forestville P.G.

21c. (City or town) (County)

Forestville P.G.

(State)

Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

May 12 5:59 PM

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Slashed with chest

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE

James S. Boyd

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5-12-55

M. D.

ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

5-13-55

NAME OF CEMETERY OR CREMATORY

Rollins

LOCATION (City, town, or county)

N.E. Washington

(State)

D.C.

DATE REC'D BY LOCAL REG.

5-13-55

REGISTRAR'S SIGNATURE

Amanda Journey

24. FUNERAL DIRECTOR

Rollins

ADDRESS

Washington D.C.

Carrie Campbell.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 20 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04950

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE, (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Ohio		COUNTY 72X-3	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Seat Pleasant		LENGTH OF STAY (in this place) 1 month		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Canton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Central Avenue				STREET ADDRESS (If rural, give location) 435 Walnut Ave			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Rolland Harold Wayman				5-14-55			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, married	8. DATE OF BIRTH: 9/25/31	9. AGE last birthday: 23 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, specify if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY: U.S. Air Force		11. BIRTHPLACE (State or foreign country): Wheeling W. Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Walter H. Wayman				14. MOTHER'S MAIDEN NAME: Helen Hirsch Wayman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Balling Air Force Records			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
819X Immediate cause (a) Hemorrhage and shock							
Antecedent cause(s) (b) Crushed skull							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF INJURY: Street, office, bldg., etc.) Seat Pleasant Md		21c. (City or town) (County) (State) Seat Pleasant Md Prince Georges			
21d. TIME (Month) (Day) (Year) (Hour) 5 14 55 11 PM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? occupant of auto the skull fractured			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: James J. Bond		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED: 5-15-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 5/15/55		NAME OF CEMETERY OR CREMATORY: Washington, D.C.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG: 5/15/55		REGISTRAR'S SIGNATURE: Carrie Campbell		24. FUNERAL DIRECTOR: Rinaldo Funeral Home		ADDRESS: 816 H St. NE	

RECEIVED

MAY 20 1955

BUREAU V. S.

4952

04951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 142

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges	MARYLAND	STATE Maryland	COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Allentown	LENGTH OF STAY (in this place) 5 years	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Allentown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7140 Allentown Rd SE		STREET ADDRESS (If rural, give location) 7140 Allentown Rd SE	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Virginia	(Middle) Webb	(Last)	(Month) May (Day) 22 (Year) 1955
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Jan 16 1881
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own Home	9. AGE last birthday: 74 yrs.
11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: Trenton W. Willard		14. MOTHER'S MAIDEN NAME: Elizabeth Rider	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		17. INFORMANT & ADDRESS: Mr. Helen Webb, same address	
16. SOCIAL SECURITY No.:			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
442X Immediate cause (a) Cerebral thrombosis		
Antecedent cause(s) (b) Cardiovascular renal disease		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE James D. Long		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5-22-55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 5-25-55	NAME OF CEMETERY OR CREMATORY Washington National Cemetery
DATE REC'D BY LOCAL REG 5/24/55	REGISTRAR'S SIGNATURE Amanda Downey	LOCATION City, town, or county (State) Hyattsville, Md.
24. FUNERAL DIRECTOR		ADDRESS
J. Jacob's Sons		
Carrie Campbell		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4926

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G181 5-18-55 et

04952

CERTIFICATE OF DEATH

Reg. Dist. No. 231...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince George</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince George</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 TOWN <i>Chesley</i>		20 days		41 TOWN <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
177 Prince Geo Gen Hosp				620 - H Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
EVANS, Wesley				May 1 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M.	Colored	Married	27 April 1875	77 - 80 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Laborer Freed Store				Maryland			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Wesley				Lilly Carter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		213-05-1922		Evans Wesley Jr, 620 27th St Laurel Md			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
177X IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Edema & Congestion of lungs.							
(B) Cancer of Prostate..							
(C) Heart hypertrophy. Congestion of liver							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
2							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from 4-20, 1955, to 5-1, 1955, that I last saw the deceased alive on 5-1, 1955, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
SIGNATURE <i>R. Bomer</i>				ADDRESS <i>Hyattsville Md</i>		DATE SIGNED <i>5-2-55</i>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 4, 1955		Muintuit Cemetery		Muintuit Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 3-55		<i>Amanda Denny</i>		Ridgely Selby		401 Wood and Laurel Md	

CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

MAY 11 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4928

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04954

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 245

I. PLACE OF DEATH:

COUNTY Prince Georges MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) 5 hrs
 TOWN University
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Seland Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY Prince Georges
 CITY (If outside corporate limits write RURAL and give nearest town) College Park
 OR TOWN 14
 STREET ADDRESS (If rural, give location) 8709 - 48th Place

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH:

4. DATE OF DEATH

(Month)

(Day)

(Year)

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyattsville, Md.)

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 5-19-55
 DEPUTY MEDICAL EXAMINER ☒
 M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-20-955 Mrs. Jas. Severed (Hyattsville, Md.)

May 20, 1955, Fort Lincoln

Colmar Manor, Md.

Gascha Soc. Hyattsville, Md.

RECEIVED

MAY 28 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04953

4927

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Prince Georges</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>38 Cheltenham</i>	LENGTH OF STAY (in this place) <i>4 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>Cheltenham</i>	TOWN <i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77 Prince Georges Gen. Hosp.</i>		STREET ADDRESS (If rural give location) <i>Box 26</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Baby Girl West</i>		DEATH: <i>5 8 19 55</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>5-4-55</i>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>Thomas Arthur West</i>		14. MOTHER'S MAIDEN NAME: <i>Catherine Pauline Savoy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <i>Statistic Card & Chart</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>762.0 Respiratory collapse</i>			
ANTECEDENT CAUSE (B) <i>Expiration of atherosclerosis?</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
		<i>16</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5/4</i> , 19 <i>55</i> , to <i>5/8</i> , 19 <i>55</i> that I last saw the deceased alive on <i>5/7</i> , 19 <i>55</i> , and that death occurred at <i>6 15</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>G. Christensen</i>		DATE SIGNED <i>5/10/55</i>	
M. D. <i>Carlson Park</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Cremation</i>	<i>5/18/55</i>	<i>Prince Georges Gen Hosp</i>	<i>Cheltenham Md</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>5/25/55</i>	<i>Alonzo Denny</i>	<i>Harry W. Penn</i>	<i>Supt</i>

2055102313

CERTIFICATE OF DEATH

NAME OF DECEASED _____

AGE _____

SEX _____

DATE OF DEATH _____

PLACE OF DEATH _____

Cause of Death _____

Signature of Physician _____

Signature of Coroner _____

Signature of Registrar _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

BUREAU V. S.

MAY 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04955

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>PR. Geo's</u>		MARYLAND		STATE <u>MD</u> COUNTY <u>PR. Geo's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>FORESTVILLE</u>		<u>15 yrs</u>		TOWN <u>FORESTVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MARIBORO PIKE</u>				STREET ADDRESS (If rural, give location) <u>MARIBORO PIKE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>EDWARD S. WOHLFARTH JR.</u>				<u>6 2 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>MARCH 18 1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>MAIL CARRIER U.S. GOVT</u>				<u>DISTRICT OF COLUMBIA</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>EDW. S. WOHLFARTH, SR.</u>				<u>SARAH VESSEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>-</u>		<u>ESTHER WOHLFARTH FORESTVILLE, MD</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Acute coronary cardiac failure</u>						<u>30 hrs</u>	
Antecedent cause(s) (b) <u>Chronic arteriosclerotic myocarditis</u>						<u>unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>General Arteriosclerosis</u>						<u>unknown</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Bronchitis</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
<u>none</u>				<u>Chronic Bronchitis</u>			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
<u>SUICIDE</u>		<u>office bldg.</u>		<u>Washington</u>		<u>MD</u>	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
<u>May 2 1955</u>		<u>While at work</u>		<u>at work</u>			
22. I hereby certify that I attended the deceased from <u>April 5, 1955</u> , to <u>May 2, 1955</u> , that I last saw the deceased alive on <u>May 2, 1955</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE)		DATE SIGNED	
<u>Paul O. Hutto</u>				<u>M.D., Washington</u>		<u>May 2 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/4/55</u>		<u>WASHINGTON NATIONAL</u>		<u>UPPER MARIBORO, MD</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 4-55</u>		<u>Edward F. Galt</u>		<u>KITCHIE BROS</u>		<u>MARIBORO, MD</u>	

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7.1

RECEIVED
MAY 9 1955
BUREAU V. S.